Idaho Medicaid DME Issues

Concern	Rationale	Proposed Solution	Name / Company
Timeliness: Medicaid urgency timeline and the physicians and patients timeline are different.	Timeliness: Physician orders their patient equipment and supplies, (ex. CPAP). The physician wants the patient setup immediately due to the medical requirements of the patient's medical condition based on the physician evaluation. The DME supplier is unable to obtain immediate authorization. Another scenario is a physician's orders for a wheelchair for a short-term length of need due to a fracture facture. The DME supplier is unable to obtain immediate authorization. 2) Idaho Medicaid may have processed the authorizations, but the DME suppliers are not receiving the information timely 3) Additional documentation is sometimes required by the DME supplier, but by the time we obtain the required additional information from the physician the time is up, (especially for the short time fractures for wheelchairs) and the physician and our patient are upset with Idaho Medicaid and us.	1) DME PA unit could fax authorizations to the supplier same day. MAVIS could have an authorization line that listed PA information per client. Idaho Medicaid could possibly set up an Internet based PA authorization process that would be live time. 2) IF short term DME equipment is ordered, the physician order would be adequate documentation for Idaho Medicaid PA approval, without a request for additional chart notes. 3) Idaho Medicaid could change wheelchair policy to not require a PA for the rental/purchase of a wheelchair until starting with the 4th rental month, and then at this time the DME supplier could provide additional documentation and PT evaluations to justify medical need. 4) Idaho Medicaid could require the ordering physician's office to be responsible for obtaining the PA for all DME related equipment and supplies that they have ordered for their patient. The physician is the clinical expert; the DME supplier is a provider of a piece of equipment or supply. The DME supplier does not make clinical decisions for Idaho Medicaid clients.	MedNow Medical Supply
Consistency: Authorization are granted with different billing/ HCPC codes and modifiers.	See attached letter	1) Standardize all codes and modifiers throughout the Idaho Medicaid DME system and the EDS system. If providers are required to bill a monthly rental with an E0601, then the code should always be E0601 not sometimes bill a monthly rental with E 0601 RR. This would apply to all rentals, wheelchairs and other items. It is understood that he NU modifier is used for purchase DME only. However, adding or not adding the RR is inconsistent across the board. 2) Standardize policy that all rental DME items require the "RR" modifier and all purchase DME items require the "NU" modifier as per federal / Medicare guidelines as well.	Mednow Medical Supply
No Retro Authorization: There are times when a retro authorization should be considered, allowed and granted by Idaho Medicaid. DME suppliers follow all the rules and proper steps and still are unable to obtain an authorization. This scenario mostly occurs for Bili Lights/Blankets and a Medicare	See attached letter	1) Standardize medical coverage criteria for the state to follow the same requirements as federal/Medicare guidelines for all Medicare covered DME equipment and supplier. This would not apply to statutorily excluded Medicare items or those items that do not meet the definition of any Medicare benefit. 2) Allow retro PA approval process for select problem items or individual unique situations. We have done as required or asked and we still can't get the item paid and if we do it is because we have done appeals it regards to the item and situation, please	Mednow Medical Supply

Concern	Rationale	Proposed Solution	Name / Company
Primary/Medicaid secondary patient for covered and non-covered Medicare items.		grant retro prior authorization when necessary for all involved.	
Communication of denial and request for additional information.	Denial or request for additional information is mailed when there is a time limit to respond.	Mail and fax the denial and or the request for additional information to allow maximum time to respond.	
Communication of change in policy and procedures.	Physical therapy Eval form created/changed in 2/2004. We were never noticed. Found out 2 mos later for a P/T.		
Wheelchair PA	Process is to slow in P/T response. Many say they don't know what is really required for passing the PA. Patient in need of wheelchair when requested - lack of training.	Let physicians know that PA is required before hand. They write scripts and tell patients to come get the chair. The patient is then mad at us when we say that PA is necessary to get the chair and at times takes up to a month if you can't get the PT or RT to get the proper paperwork back to us so we can send it to Boise for the PA.	Northwest Value Drug and Gift
Shower bench & bath accessories	Dr's need to be informed of what is covered and what is not. I would like to see a generalized list so that if a Dr. asks all we have to do is look up the list and say yes or no.	Have a list available as to what's covered so Dr's will know ahead. They just write Script, give it to patient and they come here usually being told not a covered item.	Northwest Value Drug and Gift
Running eligibility to verify Healthy Connections	Process is too slow	Online data base where you can search for names, perhaps print out a one line verification in batch format rather than 3 pages per person.	
Billing for units over the allowable - these deny even though we have a PA.	Cause delays in payment and multiple billing. EDS says it is fixed but we continue to receive denials.	Better communication between Medicaid and EDS to make sure the solutions actually work - perhaps some trials and follow up.	Leslie Rigg (ATS wheelchair)
Wheelchair/stander eval form is confusing	the form does not organize information well	I have attached a sample that includes al the information on the current form but provides better organization and includes documentation for the specific equipment.	
Not enough information as to what is needed for certain equipment (i.e. CPAP, Wheelchairs) when requesting authorization.		More information in provider manual for authorization covered items as to what criteria is needed. Would be nice to know what is required prior to sending authorization in.	Kerri Sullivan
When authorization is cancelled providers are not notified.		Send notice to provider when authorization is cancelled and why cancelled.	Kerri Sullivan
Preauthorization process merely causes delay for items that are typically covered.	Time	Would like an automated authorization system similar to SmartPA for Rx. (See attachment)	Valley Medical Shoppe
Oxygen lab results transmitted with every claim each month.	Software issues, repetitiveness	Initial Rx information should be sufficient for the length of Rx as it is with all other insurances including Medicare.	Valley Medical Shoppe
On line live claims transmittals	Cost containment, streamline the billing process, get paid for what we do.	Have system similar to Rx.	Valley Medical Shoppe

EDS DME Issues

Concern	Rationale	Proposed Solution	Name / company
Billing Process Questions	Lack of training	More training	Doug
Fee Schedules --I cannot seem to access the website. Twice billed for a discontinued code.	I cannot access the website - all I get is a rectangle w/colored shapes.	Fix it, or mail periodic paper copies to provider that request one.	Diane McGary
Denials due to not sending EOBs. I always send them, but get denials often.	The machine processing the documents doesn't recognize the EOB.	Re-check paper claims that require EOB's by hand to see if they are enclosed.	Diane McGary
Health Connections - the doctor that sends us the prescription isn't always the HC provider but doesn't know who is, or if the pt is HC. I hate calling MAVIS.	No one likes calling MAVIS		Diane McGary
Communications	"Lost carrier" Do I "resubmit?" or submit again.	Make it clear somewhere what to do when I loose the carrier. Could I get more information as to why I lost the carrier?	Sherie Tanner
Handbook	Difficulty accessing the handbook from the working screen. Haven't found an easy way to access it.	Put an icon on the toolbar or a heading for the handbook.	Sherie Tanner
Catheter Auth's - we are required to split our claims and bill separately for allowable and authorized amounts.	Doubles our workload, still denies and delays our claims processing and receiving payments from Medicaid.	Allow catheters to be billed as purchased for full amount on same claim. Make a not in Comment section: Allowable amount (4) combined with authorized amount (150) total 154 catheters per month.	Charlene Hymas
Renewed authorizations- A new PA# is given for each renewal (same item) causing denials and split claims.	Doubles our workload, denials due to claims required to be split with separate PA#'s on each claim.	Use the same PA# for each item authorized previously instead of changing each time.	Charlene Hymas
Provider numbers- other stores set up DME for our store causing authorization problems when billing Medicaid.	Doubles our workload, receiving more denials, slows sown payment process from Medicaid.	For authorizations, have only one universal provider number for Norco DME. Example: 002324706 Nampa #, 002324700 Corporate #, 002324750 Universal number, all auth's could bill out and not be required to change only by written request.	Charlene Hymas
Lack of training available	Billing process is difficult & confusing to a new biller. There are not training programs available.	You need to have training seminars where you teach us step by step how to hand bill DME supplies.	Carrie Paternoster - Floto Pharmacy
Having to bill diabetic testing supplies on paper. Time consuming, waiting for payment	Prescription drugs are billed electronically	Allow diabetic supplies to be billed like prescription drugs.	Shawnee Farnsworth
Provider Relations Consultant is not able to resolve issues related to claims.	Provider Relations Consultant does not understand Medicaid criteria and how the paperwork flows thru the EDS system. The PRC does not follow up with the provider.	EDS needs to train the PRC on the "flow", how adjustments are does etc. The PRC needs to be prompt in calling providers back and providing feedback.	unknown
Billing for units over the allowable - these deny even though we have a PA.	Cause delays in payment and multiple billing. EDS says it is fixed but we continue to receive denials.	Better communication between Medicaid and EDS to make sure the solutions actually work - perhaps some trials and follow up.	Leslie Rigg (ATS wheelchair)
When authorization is cancelled providers are not notified.		Send notice to provider when authorization is cancelled and why cancelled.	Kerri Sullivan
Preauthorization process merely causes delay for items that are typically covered.	Time	Would like an automated authorization system similar to SmartPA for Rx. (See attachment)	Valley Medical Shoppe
Oxygen lab results transmitted with every claim each	Software issues, repetitiveness	Initial Rx information should be sufficient for the length of Rx	Valley Medical

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month.		as it is with all other insurances including Medicare.	Shoppe
On line live claims transmittals	Cost containment, streamline the billing process, get paid for what we do.	Have system similar to Rx.	Valley Medical Shoppe
Talking to Real person on the phone	you can never reach an agent without leaving a message to call back	Answer phone	
Standardize Medicare and Medicaid Billing	Medicare Pays code -- same code and modifier denied by Medicaid.	Use same procedure	
Healthy Connections	Necessary to call MAVIS every billing to get doctor changes.	Educate recipient to call suppler when changing doctors.	

Issues by Topic

Authorization

Concern	Rationale	Proposed Solution
Timeliness: Medicaid urgency timeline and the physicians and patients timeline are different.	Timeliness: Physician orders their patient equipment and supplies, (ex. CPAP). The physician wants the patient setup immediately due to the medical requirements of the patient's medical condition based on the physician evaluation. The DME supplier is unable to obtain immediate authorization. Another scenario is a physician's orders for a wheelchair for a short-term length of need due to a fracture facture. The DME supplier is unable to obtain immediate authorization. 2) Idaho Medicaid may have processed the authorizations, but the DME suppliers are not receiving the information timely. 3) Additional documentation is sometimes required by the DME supplier, but by the time we obtain the required additional information from the physician the time is up, (especially for the short time fractures for wheelchairs) and the physician and our patient are upset with Idaho Medicaid and us.	1) DME PA unit could fax authorizations to the supplier same day. MAVIS could have and authorization line that listed PA information per client. Idaho Medicaid could possibly set up an Internet based PA authorization process that would be live time. 2) IF short term DME equipment is ordered, the physician order would be adequate documentation for Idaho Medicaid PA approval, without a request for additional chart notes. 3) Idaho Medicaid could change wheelchair policy to not require a PA for the rental/purchase of a wheelchair until starting with the 4th rental month, and then at this time the DME supplier could provide additional documentation and PT evaluations to justify medical need. 4) Idaho Medicaid could require the ordering physician's office to be responsible for obtaining the PA for all DME related equipment and supplies that they have ordered for their patient. The physician is the clinical expert; the DME supplier is a provider of a piece of equipment or supply. The DME supplier does not make clinical decisions for Idaho Medicaid clients.
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Wheelchair PA	Process is to slow in P/T response. Many say they don't know what is really required for passing the PA. Patient in need of wheelchair when requested - lack of training.	Let physicians know that PA is required before hand. They write scripts and tell patients to come get the chair. The patient is then mad at us when we say that PA is necessary to get the chair and at times takes up to a month if you can't get the PT or RT to get the proper paperwork back to us so we can send it to Boise for the PA.
Shower bench & bath accessories	Dr's need to be informed of what is covered and what is not. I would like to see a generalized list so that if a Dr. asks all we have to do is look up the list and say yes or no.	Have a list available as to what's covered so Dr's will know ahead. They just write Script, give it to patient and they come here usually being told not a covered item.
Wheelchair/stander eval form is confusing	the form does not organize information well	I have attached a sample that includes al the information on the current form but provides better organization and includes documentation for the specific equipment.
Not enough information as to what is needed for certain		More information in provider manual for authorization covered items

Authorization

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equipment (i.e. CPAP, Wheelchairs) when requesting authorization.		as to what criteria is needed. Would be nice to know what is required prior to sending authorization in.
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Provider numbers- other stores set up DME for our store causing authorization problems when billing Medicaid.	Doubles our workload, receiving more denials, slows sown payment process from Medicaid.	For authorizations, have only one universal provider number for Norco DME. Example: 002324706 Nampa #, 002324700 Corporate #, 002324750 Universal number, all auth's could bill out and not be required to change only by written request.
Preauthorization process merely causes delay for items that are typically covered.	Time	Would like an automated authorization system similar to SmartPA for Rx. (See attachment)
Oxygen lab results transmitted with every claim each month.	Software issues, repetitiveness	Initial Rx information should be sufficient for the length of Rx as it is with all other insurances including Medicare.

Communication

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Consistency: Authorizations are granted with different billing/HCPC codes and modifiers.	See attached letter	1) Standardize all codes and modifiers throughout the Idaho Medicaid DME system and the EDS system. If providers are required to bill a monthly rental with an E0601, then the code should always be E0601 not sometimes bill a monthly rental with E 0601 RR. This would apply to all rentals, wheelchairs and other items. It is understood that he NU modifier is used for purchase DME only. However, adding or not adding the RR is inconsistent across the board. 2) Standardize policy that all rental DME items require the "RR" modifier and all purchase DME items require the "NU" modifier as per federal / Medicare guidelines as well.
Communication of denial and request for additional information.	Denial or request for additional information is mailed when there is a time limit to respond.	Mail and fax the denial and or the request for additional information to allow maximum time to respond.
Communication of change in policy and procedures.	Physical therapy Eval form created/changed in 2/2004. We were never noticed. Found out 2 mos later for a P/T.	
Billing for units over the allowable - these deny even though we have a PA.	Cause delays in payment and multiple billing. EDS says it is fixed but we continue to receive denials.	Better communication between Medicaid and EDS to make sure the solutions actually work - perhaps some trials and follow up.
When authorization is cancelled providers are not notified.		Send notice to provider when authorization is cancelled and why cancelled.
Denials due to not sending EOBs. I always send them, but get denials often.	The machine processing the documents doesn't recognize the EOB.	Re-check paper claims that require EOB's by hand to see if they are enclosed.
Communications	"Lost carrier" Do I "resubmit?" or submit again.	Make it clear somewhere what to do when I loose the carrier. Could I get more information as to why I lost the carrier?

Communication

Concern	Rationale	Proposed Solution
Handbook	Difficulty accessing the handbook from the working screen. Haven't found an easy way to access it.	Put an icon on the toolbar or a heading for the handbook.
Provider Relations Consultant is not able to resolve issues related to claims.	Provider Relations Consultant does not understand Medicaid criteria and how the paperwork flows thru the EDS system. The PRC does not follow up with the provider.	EDS needs to train the PRC on the "flow", how adjustments are does etc. The PRC needs to be prompt in calling providers back and providing feedback.
Talking to Real person on the phone	you can never reach an absent without leaving a message to call back	Answer phone
Accessibility to staff to address questions	Who do I contact for a myriad of specific questions	I would like a list of phone numbers coordinated with the dept. or specific concern addressed at each phone number.
Lack of training available	Billing process is difficult & confusing to a new billing. There are not training programs available.	You need to have training seminars where you teach us step by step how to hand bill DME supplies.

Policy

Concern	Rationale	Proposed Solution
Running eligibility to verify Healthy Connections	Process is too slow	Online data base where you can search for names, perhaps print out a one line verification in batch format rather than 3 pages per person.
Health Connections - the doctor that sends us the prescription isn't always the HC provider but doesn't know who is, or if the pt is HC. I hate calling MAVIS.	No one likes calling MAVIS	
Healthy Connections	Necessary to call MAVIS every billing to get doctor changes.	Educate recipient to call suppler when changing doctors.

Billing

Concern	Rationale	Proposed Solution
Oxygen lab results transmitted with every claim each month.	Software issues, repetitiveness	Initial Rx information should be sufficient for the length of Rx as it is with all other insurances including Medicare.
On line live claims transmittals	Cost containment, streamline the billing process, get paid for what we do.	Have system similar to Rx.
Billing Process Questions	Lack of training	More training
Fee Schedules --I cannot seem to access the website. Twice billed for a discontinued code.	I cannot access the website - all I get is a rectangle w/colored shapes.	Fix it, or mail periodic paper copies to provider that request one.
Catheter Auth's - we are required to split our claims and bill separately for allowable and authorized amounts.	Doubles our workload, still denies and delays our claims processing and receiving payments from Medicaid.	Allow catheters to be billed as purchased for full amount on same claim. Make a not in Comment section: Allowable amount (4) combined with authorized amount (150) total 154 catheters per month.
Renewed authorizations- A new PA# is given for each renewal	Doubles our workload, denials due to claims required to be	Use the same PA# for each item authorized previously instead of

Billing

Concern	Rationale	Proposed Solution
(same item) causing denials and split claims.	split with separate PA#'s on each claim.	changing each time.
Having to bill diabetic testing supplies on paper. Time consuming, waiting for payment	Prescription drugs are billed electronically	Allow diabetic supplies to be billed like prescription drugs.
Billing for units over the allowable - these deny even though we have a PA.	Cause delays in payment and multiple billing. EDS says it is fixed but we continue to receive denials.	Better communication between Medicaid and EDS to make sure the solutions actually work - perhaps some trials and follow up.
On line live claims transmittals	Cost containment, streamline the billing process, get paid for what we do.	Have system similar to Rx.
Standardize Medicare and Medicaid Billing	Medicare Pays code -- same code and modifier denied by Medicaid.	Use same procedure
Indexing	After finding a certain item to bill how do I know if it needs PA, CMN modifier, other restrictions etc.	I would like an index cross reference so well that I can easily find all pertinent information concerning any item billed.
Coverage Facts	How is an item measured - what equals a unit- are these any limitations.	I would like clear information tied by index to each item stating what exactly constitutes one unit - the reimbursement per unit - and any limits per patient per month etc.